

Hospital Topics

First year of an inner city general practitioner community hospital

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Abstract

The first inner city general practitioner community hospital opened on 4 January 1982. This paper describes the operation of the hospital over the first 12 months. There were 316 admissions, with an average length of stay of 13 days. The average age of the patients was 73 and the most common reason for admission was disease of the respiratory system. Thirty five per cent of patients were admitted because of an acute illness and 37% were admitted on the same day as the request for admission. The policies of intermittent or phased care allowed for the admission of patients at regular intervals to relieve carers, and the assessment of the home circumstances of all patients allowed for planning the patient's return home.

Introduction

The concept of the general practitioner hospital is not new. The first cottage hospital was opened in 1859 in Cranleigh, Surrey, by Mr Albert Napper to provide "a place identical to home differing only in cleanliness, warmth, proper hygiene, and absence of overcrowding."¹ Thus began the cottage hospital movement.

The development of these hospitals coincided with the great outpouring of private Victorian munificence, and by 1934 there were 600 cottage hospitals containing some 10 000 beds.¹ The 1962 hospital plan for England and Wales aimed at concentrating resources in centralised district general hospitals and proved to be a threat to the cottage hospitals, but, supported and nurtured by their local communities, they continued to survive.²

It is difficult to define a community hospital,³ but the document produced by the Department of Health and Social Security, *Community Hospitals: Their Role and Development in the National Health Service*, captured many of their basic tenets.⁴ In essence, the community hospital is aligned with primary care, whereas the cottage hospital is aligned with secondary care; thus the community hospital may be seen as a mutation of the cottage hospital.

The results of several studies have shown that up to 70% of patients in district general hospitals do not need the high technology available in them.⁵⁻⁹ The diagnosis is straightforward for many patients and the treatment routine,⁸ but because of the nature of the home environment or the lack of support in the home it is necessary for these people to be transferred from the care of the general practitioner to that of the consultant. The community hospital obviates the need to change the responsibility for care.

This paper shows how the first inner city general practitioner community hospital extends the development of community hospitals. The hospital opened on 4 January 1982 on a two year trial, funded by the Special Trustees of St Mary's Hospital. It is in Chepstow Lodge in Bayswater and comprises four large Victorian terraced houses that have been converted for hospital use. It has 24 beds, and all 48 local general practitioners who were invited to have a contract with the health authority to use them took up the contract. They offered their services without payment for the first two years. There are no outpatient or diagnostic facilities at the hospital and there are no consultants.

The idea of such a hospital grew out of the proposed closure of one of the general hospitals in the district and was suggested by the community health council.¹⁰ The enthusiasm shown by the council and by the local general practitioners precipitated the opening in 1982 instead of 1986.

Certain features of Paddington and North Kensington make the existence of such a unit appropriate. The area is one of contrasts: it is densely populated and cosmopolitan, there are areas of poor housing and of overcrowding, there is a general lack of family support, and a large number of elderly people live alone—41% compared with 29% in England and Wales.¹¹

The community hospital

The general practitioners are responsible for providing 24 hour medical cover for their patients. This may be only by themselves or by another doctor under contract. Twenty four hour nursing cover is provided by nine trained nurses and 12 auxiliaries (whole time equivalent). A physiotherapist, an occupational therapist, and a social worker are based at Chepstow Lodge. A speech therapist, a dietitian, and a dentist visit when necessary. General practitioners may obtain the opinion of a consultant as in a home consultation. Consultants may not admit patients directly to the hospital.

The community hospital is managed by a team that meets once a month and comprises a general practitioner, the nursing officer, and an administrator. Major policy decisions are made by an advisory committee of administrative, medical, and paramedical personnel which meets every six weeks. The admission policy of the hospital allows for five categories of patient: (a) Acute medical. (b) Post-operative or other patients suitable for transfer from the district general hospitals, whose general practitioners have agreed to undertake their continued medical care. (c) Selected patients for terminal care. (d) Holiday admissions to relieve the strain on relatives. (e) Patients for rehabilitation. Children aged under 16, obstetric patients,

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and psychiatric patients are not allowed to be admitted. Patients are not admitted if it is expected that the duration of stay will be greater than 28 days, but there is a procedure for review.

A particularly important aspect is the home assessment of patients before they are admitted. A nurse, physiotherapist, occupational therapist, or social worker will visit the person and assess the home circumstances. In this way appropriate strategies for rehabilitation are planned for the patient's return home.

Methods and results

When an admission is proposed a form is completed providing information concerning the age, sex, diagnosis, reason for admission, and other details; this is linked with discharge information to calculate duration of stay.

There were 316 admissions to the general practitioner community hospital during its first year; 66% were women and 34% men. The mean (SD) duration of stay was 13 (8) days. Four per cent of patients stayed for longer than the 28 day limit. The average age of patients was 73 and 73% of patients were aged 70 or over. Figure 1 shows the age distribution. The modal age group was 80-89 years, which is similar to the age distribution found in many of the general medical wards in this district. Forty four general practitioners admitted patients; the mean number of admissions per general practitioner was 6.6 and the maximum 18.

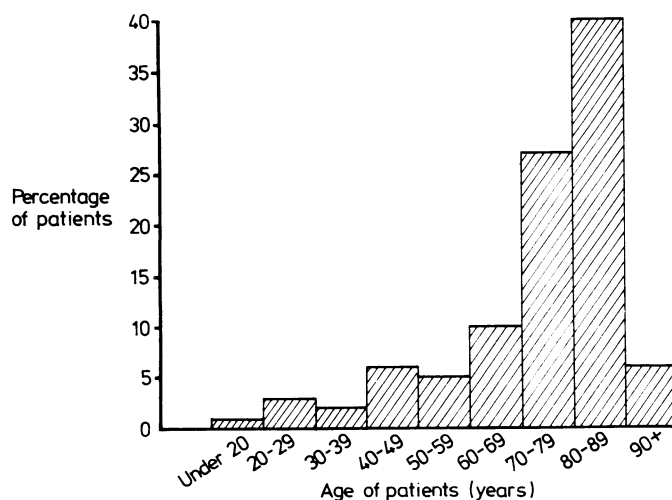


FIG 1—Age distribution of patients.

TABLE I—Frequency distribution of category of admission

Category of admission	Percentage of patients
Urgent (to be admitted same day)	37
Semiurgent (to be admitted within three days)	29
Transfers from other hospitals	16
Holiday and planned admissions	18

Two thirds of the patients were admitted urgently or semiurgently (table I). Most patients (84%) were admitted from their own homes. Of the remainder, 13% were admitted from hospitals, 1% from the general practitioner's surgery, and 2% directly from the "streets" in the case of patients with no fixed address. Most patients (85%) were discharged home again but 12% were transferred to the nearby district general hospitals, usually because of sudden deterioration in their condition. Two per cent of patients died, most of whom had been admitted for terminal care, and 1% were discharged to part 3 accommodation.

In response to the question on the admission form "What would you do if a bed were not available?" general practitioners stated that 52% of the patients admitted would have stayed at home, 39% would have been admitted to another hospital or remained in hospital if they were already there, 1% would have gone to the geriatric unit, 1% to part 3

accommodation, and in 7% of cases the general practitioners said that they did not know what they would have done.

Over a third of admissions were due to an acute illness and these patients were generally admitted the same day that the request was made (table II). Seventeen per cent of patients were admitted for rehabilitation, which encompasses physiotherapy and occupational therapy. Admissions for family relief enabled the temporary relief of strain on friends and relatives from the duties of carers. The hospital offers an intermittent or phased care scheme so that people may return to hospital at regular intervals to give support to the carers. Eighteen patients were included in this scheme and the mean interval between admissions was 16 weeks. The other reasons for admission included investigation, control of pain, dietary reasons, and the ill health of a carer.

TABLE II—Frequency distribution of the type of care for patients

Type of care	Percentage of patients
Acute illness	35
Rehabilitation	17
Family relief	15
Observation	12
Preconvalescence	8
Other	13

Table III gives the distribution of the admissions by the diagnosis. The category labelled "other" included alcoholism, dementia, incontinence, pyrexia of undetermined origin, diabetes, and anaemia. Several diagnoses in this category were described in social terms rather than physical ones, such as inability to climb stairs, unable to manage a home, unable to cope with debility.

Figure 2 shows the changes in the bed occupancy. Over the first six months the occupancy averaged 34%, for the second six months it averaged 63%.

TABLE III—Distribution of admissions by diagnosis

Diagnosis	Percentage of patients
Diseases of the respiratory system	14
Diseases of the nervous system	12
Diseases of the cardiovascular system	10
Diseases of musculoskeletal system and connective tissue	8
Diseases of the digestive system	6
Trauma	6
Postoperative rehabilitation	5
Back problems	5
Malignant neoplasms	4
Other	21
Holiday admissions	9

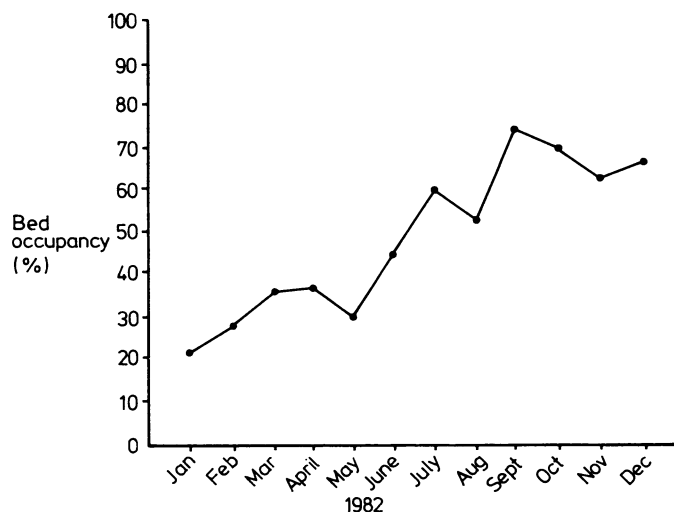


FIG 2—Bed occupancy.

Discussion

The data from the first 12 months indicate the type of patient who can be cared for in an inner city general practitioner community hospital and the ways in which the patient may benefit. For patients who prefer to be looked after by their own general practitioner the community hospital provides continuity of care. The home assessment that is carried out by the nurses or therapists from the hospital before admission benefits patients because when admitted they come into an environment where they have already met at least two people. This may alleviate some of the stress and anxiety that is created by admission. Appropriate nursing care and rehabilitation may be planned from information acquired during the home assessment.

The intermittent or phased care scheme available at the community hospital is important in alleviating the distress created by long term caring.¹² Such an approach is expected to sustain people longer in their own homes by supporting their carers, reducing their feelings of isolation, and attempting to lessen some of the burden of caring.

Terminal care is offered with a similar view in mind. In this case general practitioners can continue the care of their patients, and, in addition, the patients' carers are encouraged to come into the unit to continue the caring that they may have been doing for a long time. Thus some of the guilt that may be created by allowing the terminally ill person to be admitted to hospital may be reduced. The nurses give support when required, but the spouse, relative, or friend may continue to perform most of the caring activities.

The benefits of the general practitioner community hospital accrue to others besides patients. It has enabled the general practitioners to use their skills more and has reduced any feeling of isolation that they might have had. Cavenagh, in his study of 350 general practitioner hospitals, showed that general practitioners find the work attractive and many said that work in the general practitioner hospital was essential for job satisfaction.¹³

During the first six months of operation of this hospital the general practitioners came to terms with a new facility available to them. As well as presenting different ways of working, for some it was the first time for many years that they had cared for patients in a hospital. This was a time for adaptation and change. Over this period the bed occupancy was low, but on 21 June 1982 the general practitioners met to discuss their fears, apprehensions, and the problems that they had encountered. After this the bed occupancy rose.

A broad range of patients has been successfully cared for in the hospital and, provided that the general practitioners realise both

their own limitations and those of the community hospital and are ready to evaluate their work critically, the patients seem to benefit. Primarily they benefit from the doctors' often extensive knowledge of the wider needs of both themselves and their families so that attention may be focused on the specific requirements of rehabilitation of the patient in the home.

So far as we can tell from an extensive review of published papers, this is the first report of the development of a community hospital.

Apart from the authors the steering group for the evaluation of the operation of the hospital comprises: J Bailey, director of nursing services (community); J Hughes, project officer, King's Fund Centre; L Jacobs, general practitioner; S Linden, vice-chairman, Paddington and North Kensington Community Health Council; M Seifert, consultant rheumatologist.

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Is a diet consisting of 50-60% whole grains, especially brown rice; 25% locally grown, cooked vegetables; and 15% beans and sea vegetables, soups, and condiments sufficient to maintain health?

The details given about the diet are rather sparse, and without more details regarding the amounts of foods making up the diet it is not possible to be definitive. If eaten in adequate amounts, however, the diet would be adequate to maintain life, in that it would provide energy and a reasonable protein intake. Even so, prolonged and rigid adherence to the diet could produce nutritional deficiencies. The diet could not, therefore, be regarded as sufficient to maintain health without supplementation with selected foods in order to ensure an adequate supply of all nutrients. The more important deficiencies of the diet are the following. Firstly, it is very low in fat and whereas it would provide sufficient amounts of essential fatty acids, the provision of fat soluble vitamins (A and D) would be inadequate. The green and yellow vegetables present would provide β carotene (provitamin A) but the low fat intake would not facilitate absorption. Secondly, the water soluble B vitamin intake would be inadequate in respect of B₁₂ unless meat extracts or meats were consumed. Conservative cooking methods would be necessary

to retain any vitamin C present. Thirdly, the diet is low in calcium and high in phosphorus and a period of adaptation to the diet, plus adequate vitamin D intake, would be necessary if calcium balance was to be maintained; furthermore the diet is rich in phytates and these would probably reduce absorption of calcium, iron, and zinc. —D A T SOUTHGATE, head nutrition and food quality division, Food Research Institute, Norwich.

Why is splenomegaly but not lymph node enlargement a feature of malaria?

The spleen is the main site in which the parasites, pigment, and to some extent parasitised red cells are destroyed. Any pathological process that increases the phagocytic function that the spleen is called on to undertake results in splenomegaly. The importance of the spleen as a phagocytic organ in malaria is proved by the accumulation of malaria pigment in the spleen as the malaria attack proceeds. In chronic malaria it is common for the spleen to develop into great size because of this increased phagocytic function, whereas phagocytosis does not occur in the lymph nodes, which are invariably free of malaria pigment. —DION R BELL, reader in tropical medicine, Liverpool.